IPDR6702				NORTH CAROLINA		PAGE:	1	
	: 11/14/2004			CHECKWRITE SUMMARY REPORT				
				CCKWRITE DATE: 11/16/2004				
				FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	CLAIMS FINALIZED	CLAIMS
	PROVIDER WARE				DENTALS	DENTALS	FINALIZED	FAID
3404901	SMOKY MOUNTAINM	8505	10486	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	H/DD/SAS			NI BODGEI				
		8599	452	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	281	11358	11609	251
				BENEFIT PACKAGE.				
		0021	0.47	AMENIC THE TOTAL BO DECENTE OF				
		8931	247	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404902		0	0	*** NO DATA TO REPORT ***				
3404302	BLUE RIDGE COMM UNITY		0	NO DATA TO REPORT				
		0	n			_		
		-			0	0	0	-
3404904	WESTERN HIGHLAN	8599	174	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				-
	DS LME		<u> </u>	BENEFIT PACKAGE.				<u> </u>
			22					
		167	33	NO CHARGE BILLED. ENTER BILLED AMOUNT AND SUBMIT DETAIL AS	2.4	292	2119	1827
				A NEW CLAIM				1
			0.0					
		11	28	CLIENT NOT ELIGIBLE ON SERVICE DATE				
2404005		0	0	Att NO DATE TO DEPORT that				
3404905	TREND COMM MENT AL HLTH CTR	0	U	*** NO DATA TO REPORT ***				
	AL HEIR CIK							
		0	0					
		0	U		0	0	0	0
3404907	RUTHERFORD-POLK	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404910	PATHWAYS	11	250	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
		8599	159	DETAIL NOT COVERED BY COMBINAT	0	594	4047	3453
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	-		<del>                                     </del>	1
								1
		27	64	DIAGNOSIS CODE MISSING OR INVA				
				LID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUB	1		-	-
		1						
3404912	CATAWBA COUNTYM	8931	91	AMTNC INCLIGIBLE TO RECEIVE SE				
	ENTAL HEALT			RVICES IN IPRS.	-		-	
								1
		8000	31	NO RATE AVAILABLE ON FILE TO P	99	171	1245	1074
				RICE THIS CLAIM DETAIL	1		1	1
		<u> </u>					<u> </u>	
-		8599	20	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				1
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	-		-	
3404913	MECKLENBURG COM	8933	458	ADTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
	ENTAL HEALT			MYLOGO IN IERO.	1		1	1
		8599	359	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	564	1257	4443	3186
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	-		-	-
		1	1		<b> </b>			t
		8517	112	CLAIMS DENIED, SUBMITTED BEYON				
		8517	112	CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM				

DROHITESS		HEAL DEVICE	WINDER OF		ļ		TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
HOPIDER	PROVIDER NAME	EODS	DENTALD	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404916	CROSSROADS BEHA	8517	162	CLAIMS DENIED, SUBMITTED BEYON				
	VIORAL HEAL			D FILING TIMELIMIT. JULY				
				THROUGH APRIL DOS MUST BE SUBM				
		8518	159	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. MAY AND	0	337	398	61
				JUNE DOS MUST BE SUBMITTED BY				
		11	7	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
2404047		2.0	1504					
3404917	CENTERPOINT HUM	11	1584	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	AN SERVICES			DAIL				
		8599	429	DETAIL NOT COVERED BY COMBINAT	291	2541	8297	5756
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		2024	1.40					
		8931	140	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
	1	+			<del> </del>	1		
	+							
3404918	ROCKINGHAM CO M	11	311	CLIENT NOT ELIGIBLE ON SERVICE				
	ENTAL HEALT			DATE				
	1	8599	34	DETAIL NOT COVERED BY COMBINAT	1			
		0399	34	ION OF RECIPIENT, PROVIDER AND	19	379	767	388
				BENEFIT PACKAGE.				
		8935	15	ASTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404919		8517	178	CLAIMS DENIED, SUBMITTED BEYON				
2404313	GUILFORD CO MEN TAL HEALTHC	0317	170	D FILING TIMELIMIT. JULY				
	TAL REALING			THROUGH APRIL DOS MUST BE SUBM				
		8599	144	DETAIL NOT COVERED BY COMBINAT	17	449	6810	6361
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8518	43	CLAIM DENIED, SUBMITTED BEYOND				
		0310	4.5	FILING TIMELIMIT. MAY AND				
				JUNE DOS MUST BE SUBMITTED BY				
3404920	ALAMANCE CASWEL	8599	234	DETAIL NOT COVERED BY COMBINAT				
	L AREA MH D			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8000	31	NO RATE AVAILABLE ON FILE TO P	12	24.0	4751	4400
				RICE THIS CLAIM DETAIL	12	319	4/51	4432
		537	20	PROCEDURE IS NOT COVERED FOR T				
	1			HIS DATE OF SERVICE				
	1	+			-			
3404921	OPANGE DEPON C	7702	971	IPRS DOES NOT ACCEPT ONE OR MO	<del> </del>	1		
	ORANGE PERSON C HATHAM AREA			RE OF THE BILLED MODIFIERS				
				PLEASE CORRECT THE MODIFIER IN	l .			
		5312	580	PRIOR AUTHORIZED DOLLARS EXCEE	40	1901	5189	3288
	1			DED				
	1	+			-			
	1	8599	81	DETAIL NOT COVERED BY COMBINAT	<del> </del>	1		
	1			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404922	THE DURHAM CENT	21	251	DUPLICATE OF CLAIM-SYSTEM				
	ER				1			
	1	+	1		-			<u> </u>
	+	8517	80	CLAIMS DENIED, SUBMITTED BEYON		270	630	252
	+		-	D FILING TIMELIMIT. JULY	0	379	630	251
	1			THROUGH APRIL DOS MUST BE SUBM				
		8518	32	CLAIM DENIED, SUBMITTED BEYOND				
	1			FILING TIMELIMIT. MAY AND				
				JUNE DOS MUST BE SUBMITTED BY				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
	THOUSE HIERE				Danting	DINTITIO	111111111111111111111111111111111111111	11111
3404923	VGFW AREA AUTHO	11	142	CLIENT NOT ELIGIBLE ON SERVICE				
	RITY			DATE				
		8599	60	DETAIL NOT COVERED BY COMBINAT	C	218	1453	1235
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8518	7	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. MAY AND				
				JUNE DOS MUST BE SUBMITTED BY				
3404925	SANDHILLS CENTE	8599	317	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8517	267	CLAIMS DENIED, SUBMITTED BEYON	46	1125	2393	1268
				D FILING TIMELIMIT. JULY				
				THROUGH APRIL DOS MUST BE SUBM				
		21	137	DUPLICATE OF CLAIM-SYSTEM				
		1	1		1			<b> </b>
	+	+	<del>                                     </del>		+			
3404926	SOUTHEASTERN RE	11	212	CLIENT NOT ELIGIBLE ON SERVICE	+			<b> </b>
	G MENTAL HL	+	<del>                                     </del>	DATE	+			
	O SERVINE III	+	1		1	1		
	+	+			+			<b> </b>
	+	8517	170	CLAIMS DENIED, SUBMITTED BEYON		971	2000	0715
	+	+	1	D FILING TIMELIMIT. JULY	69	9/1	3686	2715
	+	+	+	THROUGH APRIL DOS MUST BE SUBM	+	1		
		21	145	DUPLICATE OF CLAIM-SYSTEM				
3404927	CUMBERLAND CO M	8505	1586	CLAIM DENIED DUE TO INSUFFICIE				
	HC HC			NT BUDGET				
	HC			NI DODOLI				
		8599	174	DETAIL NOT COVERED BY COMBINAT		1000	3411	4570
		0333	274	ION OF RECIPIENT, PROVIDER AND	-	1833	3411	1578
				BENEFIT PACKAGE.				
				DENELLI LIGITADE.				
		27	32	DIAGNOSIS CODE MISSING OR INVA				
				LID. VERIFY AND ENTER THE				
				CORRECT DIAGNOSIS CODE AND SUB				
				CONNECT DINONOCTO CODE IND COD				
3404929		8952	15	CLAIM DENIED DUE TO AGE RESTRI				
3404323	LEE HARNETT MH/	0332	10	CTIONS FOR TARGET POPULATION				
	DD/SAS			CITORO TON THROAT TOTOMITTON				
		11	11	CLIENT NOT ELIGIBLE ON SERVICE				
		11	11	DATE		37	530	493
				DATE				
	1	8599	7	DETAIL NOT COVERED BY COMPINE	1			-
	1	8599	1	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1			-
	1	+	-	BENEFIT PACKAGE.	1			-
	1	+	-	DENELL FROM GE.	1			-
3404930		0	0	*** NO DATA TO REPORT ***	+			-
	JOHNSTON COUNTY	+	-	Dilli 10 Mil Oni	+			-
	MNTL HLTHC	+	<del>                                     </del>		+			
	+	+	<del>                                     </del>		+			
	+	0	0		+			
	+	1	-			0	0	0
	1	+	-		1			-
		8935	22	ASTNC INELIGIBLE TO RECEIVE SE	1			-
3404921	WAKE CO HUM SVC	0,33		RVICES IN IPRS.	1			-
3404931		1	1	NITODO IN IENO.	+			
3404931	BILLING OF			T. Control of the Con				
3404931	BILLING OF							
3404931	BILLING OF	0500	10	DETAIL NOT COURDED BY COMPANY				
3404931	BILLING OF	8599	12	DETAIL NOT COVERED BY COMBINAT	25	i 39	117	78
3404931	BILLING OF	8599	12	ION OF RECIPIENT, PROVIDER AND	25	39	117	78
3404931	BILLING OF	8599	12		25	39	117	78
3404931	BILLING OF		12	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	25	39	117	78
3404931	BILLING OF	8599 8931	12	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE	25	39	117	78
3404931	BILLING OF		12	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	25	39	117	78
3404931	BILLING OF		3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE	25	39	117	78
	BILLING OF		3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	25	39	117	78
	BILLING OF		3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. AMTNC INELIGIBLE TO RECEIVE SE	25	39	117	78
			3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	25	39	117	78
	RANDOLPH/SANDHI		3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	25	39	117	78
	RANDOLPH/SANDHI		3	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	25	39	117	78
3404932	RANDOLPH/SANDHI		3 3 0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	2:	39	117	78
	RANDOLPH/SANDHI		3 3 0 0 0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  AMTNC INELIGIBLE TO RECEIVE SE EVICES IN IPRS.	25		117	78

PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404933	SOUTHEASTERN CT	167	757	NO CHARGE BILLED. ENTER BILLED				
	R FOR MH/DD			AMOUNT AND SUBMIT DETAIL AS				
				A NEW CLAIM				
		8000	77	NO RATE AVAILABLE ON FILE TO P	8	950	1697	747
				RICE THIS CLAIM DETAIL				
		8599	56	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				DENTE LA LANGUAGE				
3404934	ONSLOW COUNTY B	11	45	CLIENT NOT ELIGIBLE ON SERVICE				
	EHAVIORAL H			DATE				
		8599	7	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1	. 69	600	531
				BENEFIT PACKAGE.				
		24	7	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
2404025								
3404935	WAYNE CO MENTAL HEALTH CTR		u .	*** NO DATA TO REPORT ***				
		0	0					
			-		0	0	0	0
3404936	WILSON-GREENE M	21	13	DUPLICATE OF CLAIM-SYSTEM				
	ENTAL HEALT							
		0000						
		8931	3	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	4	22	233	211
		8932	1	CMTNC INELIGIBLE TO RECEIVE SE				
		0932	1	RVICES IN IPRS.				
3404937		8625	1	SIX OCCURRENCES OF ASAO SERVIC				
	EDGECOMBE NASH MNTL HLTH C			ES HAVE PROCESSED AND PAID, PA				
				IS REQUIRED FOR ADDITIONAL SER				
		0	0			1	236	
						1	230	-
2404020		0500	40	DEBATT NOR COURDED BY COMPANIE				
3404938	VGFW DBA RIVERS TONE COUNSE	8599	40	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8625	15	SIX OCCURRENCES OF ASAO SERVIC				
		0023	15	ES HAVE PROCESSED AND PAID, PA	16	86	1092	1006
				IS REQUIRED FOR ADDITIONAL SER				
		24	9	PROCEDURE CODE, PROCEDURE/MODI				
			-	FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
3404939	NEUSE MENTAL HE	11	16	CLIENT NOT ELIGIBLE ON SERVICE	<del>                                     </del>			
	ALTH CENTER			DATE				
		0	0		0	16	17	1
3404941	PITT CO MH/DD/S	8599	278	DETAIL NOT COVERED BY COMBINAT				
	PITT CO MH/DD/S AS CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	75	CLIENT NOT ELIGIBLE ON SERVICE	6	449	1120	671
				DATE		449	1120	0/1
		21	35	DUPLICATE OF CLAIM-SYSTEM				
3404942	ROANOKE CHOWANH	8599	36	DETAIL NOT COVERED BY COMBINAT				
	UMAN SERVIC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.	1			
		8517	23	CLAIMS DENIED, SUBMITTED BEYON	7	81	1486	1405
				D FILING TIMELIMIT. JULY				
				THROUGH APRIL DOS MUST BE SUBM	<del>                                     </del>			
		21	7	DUPLICATE OF CLAIM-SYSTEM				
			1	The state of the s	1	1	i e	

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
	THOVEDER HEED				DIMITIO	DENTITED	I IMIDIDD	11120
3404943	ALBEMARLE MENTA	537	28	PROCEDURE IS NOT COVERED FOR T				
				HIS DATE OF SERVICE				
	L HEALTH CE			HIS DATE OF SERVICE				
		11	19	CLIENT NOT ELIGIBLE ON SERVICE	22	148	1518	1370
				DATE				
		191	18	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
	_			<del> </del>				
2404044		0.4	0.04					
3404944	EASTPOINTE HUMA	21	204	DUPLICATE OF CLAIM-SYSTEM				
	N SERVICES							
		8599	89	DETAIL NOT COVERED BY COMBINAT	43	444	1719	1275
				ION OF RECIPIENT, PROVIDER AND			2,12	
				BENEFIT PACKAGE.				
	_		-					l
		8621	63	60 RESIDENTIAL LEVEL III TREAT				
				MENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
3404946	FOOTHILLS AREAM	8599	827	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
	ENIAL REALI			BENEFIT PACKAGE.				
				BENEFII FACINGE.				
		11	404	CLIENT NOT ELIGIBLE ON SERVICE	6	1325	4978	3653
				DATE				
		143	50	CLIENT ID NUMBER NOT ON STATE				
	_			ELIGIBILITY FILE				
				DD101D1111 11DD				
			_					
3404957	TIDELAND MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0			0	90	90
	+	1	-	+			90	90
			_					<del>                                     </del>
3404959		0	0	*** NO DATA TO REPORT ***				1
7404323	DAVIDSON CO MEN	v	U	NO DATA TO REPORT ***				
	TAL HLTH CT							
						<u> </u>		
		0	0		(	0	0	0
								†
								1
3404979	NEW RIVER AREAM	21	15	DUPLICATE OF CLAIM-SYSTEM				<del>                                     </del>
		1	-					l
	H/DD/SA PRO							-
						<u> </u>		
		11	11	CLIENT NOT ELIGIBLE ON SERVICE	3	41	446	405
				DATE				
		8599	8	DETAIL NOT COVERED BY COMBINAT				-
		0333	~	ION OF RECIPIENT, PROVIDER AND				
	1							
	1	1	1	BENEFIT PACKAGE.	1	1		